PUBLICATION

Health Reform Rules Finalized for Summary of Health Benefits Coverage Requirements

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On February 14, 2012, three federal agencies published final rules that implement the Patient Protection and Affordable Care Act (ACA) requirement that employers, insurers and plan administrators provide an easy to understand summary of benefits and coverage and a glossary of terms. The stated purposes of the rules are to help consumers make an "apples-to-apples" comparison as they shop for insurance and to prevent insurers from using fine print to hide important information about what services are covered by the plan. Action must be taken swiftly to ensure compliance by the deadline, which in some cases is as early as September 23, 2012.

The final rules implement Section 2715 of ACA, which requires that the summary of benefits and coverage (SBC) be not more than four pages in length and must be presented in a manner that is understandable by the average enrollee. The SBC is to include a summary of basic plan features, for each benefit package offered, along with coverage examples that demonstrate how a plan would work in the case of pregnancy or serious or chronic medical conditions.

Plans Covered by the Rule

Both group health plans and health insurance issuers offering group or individual health insurance coverage – regardless of grandfather status – are required to abide by the SBC requirements. Therefore, plans in the individual, small group and large group markets are required to provide the SBC in writing and free of charge. This includes both self-insured plans and third-party insured plans. The regulators outline three different scenarios under which an SBC will be provided: 1) by a group health insurance issuer to a group health plan or to its sponsor (generally the employer); 2) by a group health insurance issuer or sponsor or administrator of a group health plan to participants and beneficiaries; and 3) by a health insurance issuer to individuals and dependents in the individual market. An SBC must be provided upon application for insured coverage, again by the first day of coverage (if the information in the SBC has changed since the application); as well as upon renewal or reissuance and upon request. In addition, a notice of material modification of the content of a previously provided SBC must be provided at least 60 days before the effective date of the change.

Several commentators asked that regulators exempt large group and self-insured plans, but regulators declined to offer this exemption. Regulators go on to state that an SBC does not need to be provided for excepted-benefit packages, such as stand-alone dental or vision plans or health flexible spending arrangements (FSA) if they constitute excepted benefits under the Departments' regulations. However, if an FSA does not entirely constitute excepted benefits, it is covered by the rule.

Additionally, health savings account (HSA) programs do not need to issue SBCs. However, the SBC is required for the qualified high-deductible health plan that the HSA accompanies. In addition, a health reimbursement account (HRA) generally must distribute an SBC unless all of the HRA benefits are excepted benefits.

Content Requirements

The SBC must include a total of 12 required content elements, including the following:

1. uniform definitions of standard insurance terms and medical terms;
2. description of the coverage, including cost-sharing, for each category of benefits;
3. exceptions, reductions and limitations of coverage;
4. cost-sharing provisions, including deductible, coinsurance and copayment obligations;
5. renewability and continuation of coverage provisions;
6. A coverage facts label that includes examples to illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing based on recognized clinical practice guidelines;
7. with respect to coverage beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage, as required by ACA and whether the coverage share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;
8. a statement that the SBC is only a summary and that the plan document should be consulted to determine governing contractual provisions of the coverage;
9. contact information for questions and obtaining a copy of the plan document or insurance policy, certificate or contract of insurance;
10. for plans or issuers that maintain one or more networks of providers, an internet address for obtaining a list of network providers;
11. an internet address for obtaining the uniform glossary that provides uniform definitions, of health coverage related terms and medical terms, as specified by this regulation; and
12. for plans and issuers that maintain a prescription drug formulary, an internet address where an individual may find more information about drug coverage. The final rule **does not** require the SBC to include premium or cost of coverage information.

The SBC template and detailed instructions for completing the SBC, including coverage examples, were issued separately in sub-regulatory guidance and can be found on cms.gov.

Who Must Receive the SBC

Some who commented on the draft rule requested that regulators require that SBCs go only to plan participants, not beneficiaries. The final rule states that the SBC must be provided to both the participants and beneficiaries of the plan. However, the rule contains an anti-duplication provision under which a single SBC may be provided to a family unless any beneficiaries are known to reside at a different address.

Date of Implementation

The SBC requirements apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through the open enrollment period beginning on the first day of the open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll in group health plan coverage other than through open enrollment (for example those who are newly eligible for coverage), the regulations apply on the first day of the first plan year that begins on or after September 23, 2012.

For disclosures to plans, and to individuals and dependents in the individual market, these requirements apply to health insurance issuers beginning on September 23, 2012.

The final rule includes details on the timing requirements to help address issues raised by commentators about administrative challenges that might exist, for example in the case of renewal of coverage.

If you have questions about this or any aspect of the Patient Protection and Affordable Care Act and how it will affect you, your business and your employees, please contact a member of the Health Care Reform group.